		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043406

Facility Name: WOODSIDE EXTENDED CARE

Address: 120 WEST 26TH ST (Number) SO.CHICAGO HTS. (City) 60411 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 39-4153529

Date of Initial License for Current Owners: 11/01/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT			X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.				Individual		State
	Trust				Partnership		County
IRS Exemption Code					Corporation		Other
					"Sub-S" Corp.		
				X	Limited Liability Co.		
					Trust		
					Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) MANAGER

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,360	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,926	2,926	8
9	SNF/PED					9
10	ICF	35,010	365	535	35,910	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,010	365	3,461	38,836	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.00%

D. How many bed-hold days during this year were paid by Public Aid?
1,112 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 2,926

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	130,014	13,455	11,723	155,192		155,192	0	155,192			1
2	Food Purchase		146,018		146,018		146,018	(489)	145,529			2
3	Housekeeping	93,533	22,991	0	116,524		116,524	0	116,524			3
4	Laundry	38,566	12,357	3,739	54,662		54,662	0	54,662			4
5	Heat and Other Utilities			72,489	72,489		72,489	222	72,711			5
6	Maintenance	28,285	17,933	24,349	70,567		70,567	3,385	73,952			6
7	Other (specify):*			7,683	7,683		7,683	83	7,766			7
8	**TOTAL General Services**	290,398	212,754	119,983	623,135	0	623,135	3,201	626,336			8
	B. Health Care and Programs											
9	Medical Director	0		9,175	9,175		9,175	0	9,175			9
10	Nursing and Medical Records	985,698	77,101	14,487	1,077,286		1,077,286	0	1,077,286			10
10a	Therapy	22,346		3,129	25,475		25,475	0	25,475			10a
11	Activities	86,340	3,489	3,816	93,645		93,645	0	93,645			11
12	Social Services	0		2,799	2,799		2,799	0	2,799			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			5,538	5,538		5,538	0	5,538			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,094,384	80,590	38,944	1,213,918	0	1,213,918	0	1,213,918			16
	C. General Administration											
17	Administrative	99,181		306,500	405,681		405,681	(209,846)	195,835			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			30,305	30,305		30,305	7,171	37,476			19
20	Dues, Fees, Subscriptions & Promotions			19,158	19,158		19,158	(2,892)	16,266			20
21	Clerical & General Office Expenses	81,082	21,538	71,303	173,923		173,923	(20,589)	153,334			21
22	Employee Benefits & Payroll Taxes			274,097	274,097		274,097	0	274,097			22
23	Inservice Training & Education			1,831	1,831		1,831	69	1,900			23
24	Travel and Seminar			635	635		635	(433)	202			24
25	Other Admin. Staff Transportation			4,764	4,764		4,764	535	5,299			25
26	Insurance-Prop.Liab.Malpractice			58,345	58,345		58,345	2,478	60,823			26
27	Other (specify):*			542,968	542,968		542,968	(536,287)	6,681			27
28	**TOTAL General Administration**	180,263	21,538	1,309,906	1,511,707	0	1,511,707	(759,794)	751,913			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,565,045	314,882	1,468,833	3,348,760	0	3,348,760	(756,593)	2,592,167			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WOODSIDE EXTENDED CARE #0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			27,320	27,320		27,320	(10,060)	17,260			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			14,686	14,686		14,686	1,129	15,815			32
33	Real Estate Taxes			239,007	239,007		239,007	222	239,229			33
34	Rent-Facility & Grounds			553,583	553,583		553,583	0	553,583			34
35	Rent-Equipment & Vehicles			25,644	25,644		25,644	3,089	28,733			35
36	Other (specify):* **OFFICE RENT**			6,451	6,451		6,451	(6,451)	0			36
37	**TOTAL Ownership**			866,691	866,691	0	866,691	(12,071)	854,620			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		50,845	37,876	88,721		88,721	0	88,721			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			61,320	61,320		61,320	0	61,320			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	50,845	99,196	150,041	0	150,041	0	150,041			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,565,045	365,727	2,434,720	4,365,492	0	4,365,492	(768,664)	3,596,828			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(11,132)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(489)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(433)	24		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,160)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(542,968)	27		24
25	Fund Raising, Advertising and Promotional	(95)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(183)	20		28
29	Other-Attach Schedule SEE PAGE 5A	1,181			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (557,279)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(211,385)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (211,385)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (768,664)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WOODSIDE EXTENDED CARE

ID# 0043406

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1,181	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	1,181		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(489)	0	0	0	0	0	0	0	0	0	0	(489)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	222	0	0	0	0	0	0	0	0	222	5
6	Maintenance	1,181	1,584	620	0	0	0	0	0	0	0	0	3,385	6
7	Other (specify):*	0	83	0	0	0	0	0	0	0	0	0	83	7
8	**TOTAL General Services**	692	1,667	842	0	0	0	0	0	0	0	0	3,201	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(209,846)	0	0	0	0	0	0	0	0	(209,846)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,776	395	0	0	0	0	0	0	0	0	7,171	19
20	Fees, Subscriptions & Promotions	(3,438)	546	0	0	0	0	0	0	0	0	0	(2,892)	20
21	Clerical & General Office Expenses	0	(26,127)	5,538	0	0	0	0	0	0	0	0	(20,589)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	69	0	0	0	0	0	0	0	0	0	69	23
24	Travel and Seminar	(433)	0	0	0	0	0	0	0	0	0	0	(433)	24
25	Other Admin. Staff Transportation	0	120	415	0	0	0	0	0	0	0	0	535	25
26	Insurance-Prop.Liab.Malpractice	0	1,800	678	0	0	0	0	0	0	0	0	2,478	26
27	Other (specify):*	(542,968)	4,451	2,230	0	0	0	0	0	0	0	0	(536,287)	27
28	**TOTAL General Administration**	(546,839)	(12,365)	(200,590)	0	0	0	0	0	0	0	0	(759,794)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(546,147)	(10,698)	(199,748)	0	0	0	0	0	0	0	0	(756,593)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(11,132)	305	767	0	0	0	0	0	0	0	0	(10,060)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	333	796	0	0	0	0	0	0	0	0	1,129	32
33	Real Estate Taxes	0	0	222	0	0	0	0	0	0	0	0	222	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	2,045	1,044	0	0	0	0	0	0	0	0	3,089	35
36	Other (specify):*	0	0	(6,451)	0	0	0	0	0	0	0	0	(6,451)	36
37	**TOTAL Ownership**	(11,132)	2,683	(3,622)	0	0	0	0	0	0	0	0	(12,071)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(557,279)	(8,015)	(203,370)	0	0	0	0	0	0	0	0	(768,664)	45

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				EKS MGMT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
SEE ATTACHED SCHEDULES				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	OUTSIDE CLERICAL	$ 52,616	EKS MANAGEMENT		$	$ (52,616)	1
2	V	6	MAINTENANCE		" "		1,584	1,584	2
3	V	7	SCAVENGER		" "		83	83	3
4	V	19	PROFESSIONAL FEES		" "		6,776	6,776	4
5	V	20	WANT ADS		" "		546	546	5
6	V	21	CLERICAL		" "		26,489	26,489	6
7	V	23	SEMINARS		" "		69	69	7
8	V	25	STAFF TRANSPORTATION		" "		120	120	8
9	V	26	INSURANCE		" "		1,800	1,800	9
10	V	27	EMPLOYEE BENEFITS		" "		4,451	4,451	10
11	V	30	SL DEPRECIATION		" "		305	305	11
12	V	32	INTEREST-INSURANCE FIN.		" "		333	333	12
13	V	35	EQUIPMENT RENT				2,045	2,045	13
14	Total			$ 52,616			$ 44,601	$ * (8,015)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		17	MANAGEMENT FEES	$ 221,500	EMI ENTERPRISES		$	$ (221,500)	15
16	V		17	OFFICERS SALARY		" "		11,654	11,654	16
17	V		19	ACCOUNTING FEES		" "		343	343	17
18	V		21	CLERICAL		" "		5,317	5,317	18
19	V		25	STAFF TRANSPORTATION		" "		415	415	19
20	V		26	INSURANCE		" "		621	621	20
21	V		27	EMPLOYEE BENEFITS		" "		2,230	2,230	21
22	V		30	SL DEPRECIATION		" "		239	239	22
23	V		35	AUTO LEASE		" "		1,044	1,044	23
24	V									24
25	V		36	OFFICE RENT	6,451	IME REALTY			(6,451)	25
26	V		5	UTILITIES		" "		222	222	26
27	V		6	REPAIRS/MAINTENANCE		" "		620	620	27
28	V		19	PROFESSIONAL FEES		" "		52	52	28
29	V		21	OFFICE EXPENSE		" "		221	221	29
30	V		26	INSURANCE		" "		57	57	30
31	V		30	SL DEPRECIATION		" "		528	528	31
32	V		32	INTEREST		" "		796	796	32
33	V		33	REAL ESTATE TAX		" "		222	222	33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 227,951			$ 24,581	$ * (203,370)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	ALLOCATION FROM EMI ENTERPRISES:				SEE ATTACHED				$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT CONSUL	40.00	SCHEDULE	5	13.80	SALARY	11,654	17-7	2
3											3
4											4
5	PHILIP ESFORMES	MGMT CONSULT	MGMT CONSUL	22.50				MGMT FEE	85,000	17-3	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 96,654		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 3737 W ARTHUR
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	CENSUS DAYS	616,513	11 FACILITIES	$ 25,141	$	38,836	$ 1,584	1
2	7	SCAVENGER	" "	616,513	11 FACILITIES	1,310		38,836	83	2
3	19	PROFESSIONAL FEES	" "	616,513	11 FACILITIES	107,563	91,129	38,836	6,776	3
4	20	WANT ADS	" "	616,513	11 FACILITIES	8,660		38,836	546	4
5	21	CLERICAL	" "	616,513	11 FACILITIES	420,511	316,407	38,836	26,489	5
6	23	SEMINARS	" "	616,513	11 FACILITIES	1,100		38,836	69	6
7	25	STAFF TRANSPORTATION	" "	616,513	11 FACILITIES	1,912		38,836	120	7
8	26	INSURANCE	" "	616,513	11 FACILITIES	28,579		38,836	1,800	8
9	27	EMPLOYEE BENEFITS	" "	616,513	11 FACILITIES	70,657		38,836	4,451	9
10	30	SL DEPRECIATION	" "	616,513	11 FACILITIES	4,837		38,836	305	10
11	32	INTEREST-INSUR FINANCING	" "	616,513	11 FACILITIES	5,286		38,836	333	11
12	35	EQUIPMENT RENT	" "	616,513	11 FACILITIES	32,463		38,836	2,045	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 708,019	$ 407,536		$ 44,601	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 3737 W ARTHUR
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	CENSUS DAYS	616,513	11 FACILITIES	$ 185,000	$ 185,000	38,836	$ 11,654	1
2	19	ACCOUNTING FEES	" "	616,513	11 FACILITIES	5,451		38,836	343	2
3	21	CLERICAL	" "	616,513	11 FACILITIES	84,399	60,672	38,836	5,317	3
4	25	STAFF TRANSPORTATION	" "	616,513	11 FACILITIES	5,763		38,836	363	4
5	26	INSURANCE	" "	616,513	11 FACILITIES	9,863		38,836	621	5
6	27	EMPLOYEE BENEFITS	" "	616,513	11 FACILITIES	35,399		38,836	2,230	6
7	30	SL DEPRECIATION	" "	616,513	11 FACILITIES	3,788		38,836	239	7
8	35	AUTO LEASE	" "	616,513	11 FACILITIES	16,569		38,836	1,044	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 346,232	$ 245,672		$ 21,811	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY
Street Address: 3737 W ARTHUR
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	203,249	11 + FACIL	$ 6,990	$	6,451	$ 222	1
2	6	REPAIRS/MAINTENANCE	" "	203,249	11 + FACIL	19,525		6,451	620	2
3	19	PROFESSIONAL FEES	" "	203,249	11 + FACIL	1,650		6,451	52	3
4	21	OFFICE EXPENSE	" "	203,249	11 + FACIL	6,958		6,451	221	4
5	26	INSURANCE	" "	203,249	11 + FACIL	1,798		6,451	57	5
6	30	SL DEPRECIATION	" "	203,249	11 + FACIL	16,647		6,451	528	6
7	32	INTEREST	" "	203,249	11 + FACIL	25,074		6,451	796	7
8	33	REAL ESTATE TAX	" "	203,249	11 + FACIL	15,815		6,451	502	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 94,457	$		$ 2,998	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: IME REALTY		X	MORTGAGE			$	$			$ 796	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BRICKYARD BANK		X	WORKING CAPITAL	$1,578.00	11/98	150,000	0	10/2002	9.5000	9,945	6
7	INSURANCE FINANCING		X	INSURANCE FINANCING							3,276	7
8	FIRST EQUITY		X	WORKING CAPITAL	$0.00	11/30/01	300,000	300,000	11/30/02	PRIME +1	1,465	8
9	TOTAL Facility Related				$1,578.00		$ 450,000	$ 300,000			$ 15,482	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 450,000	$ 300,000			$ 15,482	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	228,770	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	232,727	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,957	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	235,050	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	239,007	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	137,696	8
	1997	200,823	9
	1998	215,360	10
	1999	226,504	11
	2000	232,727	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WOODSIDE EXTENDED CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043406

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-29-401-011-0000	NURSING HOME	$ 232,726.98	$ 232,726.98
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 232,726.98	$ 232,726.98

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,900 B. General Construction Type: Exterior CONCRETE Frame METAL/CONCRETE Number of Stories 1 + BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$ 0	3

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CEILING LIGHTING			1997	3,746	96	39	96		396	9
10	WATER SOFTENING SYSTEM			1997	6,926	178	39	178		734	10
11	FLOORING			1997	3,910	100	39	100		404	11
12	FLOORING / DOORS / WINDOWS			1998	29,194	748	39	748		2,718	12
13	ROOF			1998	84,450	2,165	39	2,165		8,393	13
14	DUMBWAITER/FAUCETS/CABINETS/WALLPAP./CUB.CURT.			1998	30,915	793	39	793		3,083	14
15	PAINTING / DECORATING			1998	15,111	387	39	387		1,371	15
16	FLOORING / DOORS / BATHROOM FIXTURES			1999	11,198	288	39	288		844	16
17	CHAIN LINK FENCE			1999	5,100	131	39	131		322	17
18	FLOOR TILES/COVE BASE			2000	22,766	828	27.5	828		1,621	18
19	PAIR OF ALUMINUM DOORS			2000	2,193	80	27.5	80		143	19
20	PLUMBING			2000	9,913	360	27.5	360		405	20
21	PLUMBING / VANITY / SINK / FLOORING			2001	37,788	1,002	27.5	1,002		1,002	21
22	DRAPERIES			2001	7,578	1,516	10	379	(1,137)	379	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	RELATED PARTY ALLOCATION - IME REALTY					433		433			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 270,788	$ 9,105		$ 7,968	$ (1,137)	$ 21,815	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 106,075	$ 14,846	$ 8,108	$ (6,738)	8-15 YRS	$ 28,237	71
72	Current Year Purchases	10,753	3,802	545	(3,257)	10-15 YRS	545	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY ALLOC - EKS MGMT 305/EMI ENTERP 239/IME REALTY 95		639	639	0			74
75	TOTALS	$ 116,828	$ 19,287	$ 9,292	$ (9,995)		$ 28,782	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 387,616	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 28,392	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 17,260	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (11,132)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 50,597	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: MAJ ENTERPRISES INC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		112	11/98	$ 553,583	19		3
4	Additions							4
5								5
6								6
7	TOTAL		112		$ 553,583 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 11/01/1998
Ending 10/31/2017

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2002	$
13.	12/31/2003	$
14.	12/31/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 16,546 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	'98 FORD 350E WAGON	$ 650.00	$ 650	17
18	FACILITY USE	'01 CHEVY WAGON	699.24	8,448	18
19					19
20					20
21	TOTAL		$ #######	$ 9,098	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 25,403	$		$ 25,403	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			605			605	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			24,837			24,837	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				32,060		32,060	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RADIOLOGY/LAB/RENTALS Other (specify):	39-2					5,816		5,816	13
14	TOTAL			$		$ 50,845	$ 37,876		$ 88,721	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 17,120	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	764,354		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,464		6
7	Other Prepaid Expenses	16,355		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E.TAX ESCROW	197,027		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,057,320	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	263,210		15
16	Equipment, at Historical Cost	124,406		16
17	Accumulated Depreciation (book methods)	(96,250)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 291,366	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,348,686	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 151,361	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,037		28
29	Short-Term Notes Payable	300,000		29
30	Accrued Salaries Payable	50,772		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,072		31
32	Accrued Real Estate Taxes(Sch.IX-B)	235,050		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 770,292	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	MEMBERS' LOANS	241,723		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 241,723	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,012,015	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 336,671	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,348,686	$ 0	48

***(See instructions.)**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 800,186	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 800,186	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	144,485	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(608,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (463,515)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 336,671	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,521,506	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,521,506	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,097	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 8,097	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 0	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,529,603	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	623,135	31
32	Health Care	1,213,918	32
33	General Administration	1,511,707	33
	B. Capital Expense		
34	Ownership	866,691	34
	C. Ancillary Expense		
35	Special Cost Centers	88,721	35
36	Provider Participation Fee	61,320	36
	D. Other Expenses (specify):		
37	OUT OF PERIOD EXPENSES	10,271	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,375,763	40
41	**Income before Income Taxes (line 30 minus line 40)****	153,840	41
42	**Income Taxes**	(9,355)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 144,485	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,234	$ 54,540	$ 24.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,122	5,425	103,081	19.00	3
4	Licensed Practical Nurses	16,189	18,437	329,513	17.87	4
5	Nurse Aides & Orderlies	54,438	59,369	459,679	7.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,780	2,065	22,346	10.82	8
9	Activity Director					9
10	Activity Assistants	10,839	11,856	86,340	7.28	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,071	17,569	130,014	7.40	15
16	Dishwashers					16
17	Maintenance Workers	2,266	2,296	28,285	12.32	17
18	Housekeepers	13,361	14,179	93,533	6.60	18
19	Laundry	5,536	6,031	38,566	6.39	19
20	Administrator	2,091	2,131	99,181	46.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,439	9,254	81,082	8.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca MDS/QUAL ASSU	3,987	3,987	38,885	9.75	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,199	154,833	$ 1,565,045 *	$ 10.11	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 11,700	1-3	35
36	Medical Director	O	9,175	9-3	36
37	Medical Records Consultant	N	2,474	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,844	10-3	39
40	Physical Therapy Consultant	L	629	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		2,500	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,816	11-3	44
45	Social Service Consultant	E	2,799	12-3	45
46	Other(specify)	S			46
47	PSYCHO-SOCIAL CONSULTANT		1,404	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 39,341		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	73	586		52
53	TOTAL (lines 50 - 52)	73	$ 586		53

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LES OKUN	ADMIN	0	$ 99,181
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,181

B. Administrative - Other

Description		Amount
EMI ENTERPRISES	MGMT FEES	$ 221,500
PHILIP ESFORMES	MGMT FEES	85,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 306,500
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 3,540
MAXXSOURCE	DATA PROCESSING	1,500
HDSI	DATA PROCESSING	5,328
MID AMERICA	DATA PROCESSING	1,320
NCS	DATA PROCESSING	1,650
MUTUAL OF OMAHA	DATA PROCESSING	547
KBKB	ACCOUNTING	11,100
PERSONNEL PLANNERS	UNEMPLOYMENT CONS.	820
RICHARD PEELO	M/C COST REPORTING	4,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 30,305

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 64,291
Unemployment Compensation Insurance		39,159
FICA Taxes		118,571
Employee Health Insurance		48,076
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		4,000
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 274,097

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,480
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	278
TRUST FEES/CONTRIBUTIONS/ETC	3,160
MGMT CO ALLOCATION	546
DUES & SUBSCRIPTIONS	3,403
LICENSES & PERMITS	1,837
TRUST FEES/CONTRIBUTIONS/ETC	(3,160)
Less: Public Relations Expense	(0)
Non-allowable advertising	(95)
Yellow page advertising	(183)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,266

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	202
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 202

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1998	$ 3,384	3	$ 564	$ 1,128	$ 1,128	$ 564	$	$	$	$	$
2	PAINT/DECORATING	1999	1,851	3		309	617	617	308				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,235		$ 564	$ 1,437	$ 1,745	$ 1,181	$ 308	$	$	$	$

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $ 3,328**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **628** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **61,320**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: WOODSIDE EXTENDED CARE **#0043406** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	11,700	
	REPAIRS & MAINTENANCE		23	
			0	11,723
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,739	
			0	3,739
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		15,760	
	ELECTRICITY		43,194	
	WATER		13,535	
	CABLE TV - LOBBY		0	
			0	72,489
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,291	
	PAINTING & DECORATING		610	
	BUILDING REPAIRS		6,150	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,478	
	ELEVATOR MAINTENANCE & REPAIR		1,320	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,100	
	FIRE SERVICE		2,400	
			0	
			0	
			0	24,349
7	**OTHER**			
	SCAVENGER		7,171	
	SECURITY SERVICE		512	7,683
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,175	9,175

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	586	
	LABORATORY & XRAY EXPENSE		1,879	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B 47-2	1,404	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,474	
	PHARMACY CONSULTANT	XVIII B 39-2	4,844	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL CONSULTANT		3,300	
			0	14,487
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	THERAPY CONTRACT SERVICES		0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	629	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	2,500	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	3,129
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,816	
			0	3,816
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,799	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	2,799
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WOODSIDE EXTENDED CARE **#0043406** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		5,538	5,538
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	306,500	306,500
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,885	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	16,420	
			0	30,305
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	95	
	EMPLOYEE WANT ADS	XIX F	10,480	
	CONTRIBUTIONS	VI 20 XIX F	1,000	
	DUES & SUBSCRIPTIONS	XIX F	3,403	
	LICENSES & PERMITS	XIX F	1,837	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	183	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,160	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	19,158
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		250	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		52,616	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		18,437	
	MESSENGER SERVICE		0	
			0	71,303

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	118,571	
	UNEMPLOYMENT COMPENSATION	XIX D	39,159	
	WORKERS COMPENSATION INSURANC	XIX D	64,291	
	HOSPITALIZATION INSURANCE	XIX D	48,076	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,000	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	274,097
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,831	1,831
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	635	
			0	
			0	635
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,764	4,764
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		58,345	58,345
27	**OTHER**			
	BAD DEBTS	VI 24	542,968	
			0	542,968

GRAND TOTAL COLUMN 3 OTHER 1,468,833

WOODSIDE EXTENDED CARE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	146,018	PATIENT MEALS	116508
LESS SALES TAX	(489)	ADD EMPLOYEE MEALS	0
NET FOOD	145,529	TOTAL MEALS/YEAR	116508
TOTAL PATIENT CENSUS	38,836	NET FOOD	145529
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	116508
TOTAL PATIENT MEALS	116508	COST PER MEAL	1.25
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		